AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS

Patient's Name:_____

I hereby authorize **Luba G. Richter, DMD, PA** to initiate debit entries from the account indicated below in the amount of $_____ for _____ months. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law and NACHA rules.

Account Number: _____ **Routing Number:** _____
(9 digits)

Checking _____ Savings _____

This authorization is to remain in full force and effect until **Luba G. Richter, DMD, PA** has received written notification from _____ of its termination in such time and in such manner as to afford **Luba G. Richter, DMD, PA** a reasonable opportunity to act on it.
(your name)

I hereby authorize **Luba G. Richter, DMD, PA** to keep my signature on file and to charge my credit card account in the amount of $_____ for _____ months. I understand that this form is valid for the stated months unless I cancel the authorization through written notice of its termination in such a time and in such a manner as to afford **Luba G. Richter, DMD, PA** a reasonable time to act on it.

Name: _____ **Address:** _____

City: _____ **State:** _____ **Zip Code:** _____

Credit Card Number: _____**Expiration Date:** _____/_____

Type of Card: ____ **Visa** ____ **MasterCard** ____ **Discover**

Email Confirmation: _____

_____

Signature **Date**